

		FOR OHF USE					

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2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0037838

Facility Name: OREGON HEALTHCARE CENTER

Address: 881 SOUTH 10TH STREE OREGON 61061

County: OGLE

Telephone Number: (815) 732-7994 Fax # (815) 732-3733

IDPA ID Number: 363806980001

Date of Initial License for Current Owners: 03/01/92

Type of Ownership:

VOLUNTARY,NON-PROFIT

Charitable Corp.

Trust

IRS Exemption Code

X

PROPRIETARY

Individual

Partnership

Corporation

"Sub-S" Corp.

Limited Liability Co.

Trust

Other

GOVERNMENTAL

State

County

Other

In the event there are further questions about this report, please contact:

Name:: Steve Lavenda

Telephone Number: (847) 236 - 1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/02 to 12/31/02 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed)

(Type or Print Name)

(Title)

Paid Preparer

(Signed) See Accountants' Compilation Report Attached

(Print Name and Title) NOSHIR R. DARUWALLA, C.P.A.

(Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C. 111 Pfingsten Road, Suite 300 Deerfield, IL 60015

(Telephone) (847) 236-1111 Fax # (847) 236-1155

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001
Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number OREGON HEALTHCARE CENTER

0037838 Report Period Beginning: 01/01/02 Ending: 12/31/02

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	104	Skilled (SNF)	104	37,960	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	104	TOTALS	104	37,960	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	2,294	537	1,737	4,568	8
9	SNF/PED					9
10	ICF	13,154	7,875	11	21,040	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	15,448	8,412	1,748	25,608	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 67.46%

SEE ACCOUNTANTS' COMPILATION REPORT

D. How many bed-hold days during this year were paid by Public Aid? 0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy) N/A

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES ☐ NO ☒

I. On what date did you start providing long term care at this location?
Date started 3/1/92

J. Was the facility purchased or leased after January 1, 1978?
YES ☒ Date 3/1/92 NO ☐

K. Was the facility certified for Medicare during the reporting year?
YES ☒ NO ☐ If YES, enter number of beds certified 10 and days of care provided 1,328

Medicare Intermediary AdminaStar Federal

IV. ACCOUNTING BASIS

ACCUAL ☒ MODIFIED CASH* ☐ CASH* ☐

Is your fiscal year identical to your tax year? YES ☒ NO ☐

Tax Year: 12/31/02 Fiscal Year: 12/31/02
* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number **OREGON HEALTHCARE CENTER** # **0037838** Report Period Beginning: **01/01/02** Ending: **12/31/02**

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	163,618	9,994	6,355	179,967		179,967	(419)	179,548			1
2	Food Purchase		100,538		100,538		100,538	(330)	100,208			2
3	Housekeeping	149,363	40,213		189,576		189,576		189,576			3
4	Laundry	55,214	14,080		69,294		69,294		69,294			4
5	Heat and Other Utilities			74,581	74,581		74,581	185	74,766			5
6	Maintenance	39,334	21,136	5,315	65,785		65,785	1,148	66,933			6
7	Other (specify):*											7
8	TOTAL General Services	407,529	185,961	86,251	679,741		679,741	584	680,325			8
	B. Health Care and Programs											
9	Medical Director			3,900	3,900		3,900		3,900			9
10	Nursing and Medical Records	868,510	(11,891)	9,000	865,619		865,619	(3,041)	862,578			10
10a	Therapy			42	42		42		42			10a
11	Activities	51,339	5,258		56,597		56,597		56,597			11
12	Social Services	20,339			20,339		20,339		20,339			12
13	Nurse Aide Training			800	800		800		800			13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	940,188	(6,633)	13,742	947,297		947,297	(3,041)	944,256			16
	C. General Administration											
17	Administrative	51,140		120,000	171,140		171,140	9,862	181,002			17
18	Directors Fees											18
19	Professional Services			84,591	84,591		84,591	(63,433)	21,158			19
20	Dues, Fees, Subscriptions & Promotions			4,492	4,492		4,492	(1,131)	3,361			20
21	Clerical & General Office Expenses	71,506	2,877	25,556	99,939		99,939	32,268	132,207			21
22	Employee Benefits & Payroll Taxes			227,678	227,678		227,678		227,678			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,029	1,029		1,029	5	1,034			24
25	Other Admin. Staff Transportation			3,622	3,622		3,622	288	3,910			25
26	Insurance-Prop.Liab.Malpractice			35,376	35,376		35,376	793	36,169			26
27	Other (specify):*							9,440	9,440			27
28	TOTAL General Administration	122,646	2,877	502,344	627,867		627,867	(11,908)	615,959			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,470,363	182,205	602,337	2,254,905		2,254,905	(14,365)	2,240,540			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			14,060	14,060		14,060	32,684	46,744			30
31	Amortization of Pre-Op. & Org.							3,436	3,436			31
32	Interest			38,145	38,145		38,145	45,788	83,933			32
33	Real Estate Taxes			30,325	30,325		30,325	2,658	32,983			33
34	Rent-Facility & Grounds			341,640	341,640		341,640	(341,640)				34
35	Rent-Equipment & Vehicles							785	785			35
36	Other (specify):*											36
37	TOTAL Ownership			424,170	424,170		424,170	(256,289)	167,881			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		23,995	132,624	156,619		156,619		156,619			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			56,940	56,940		56,940		56,940			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		23,995	189,564	213,559		213,559		213,559			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,470,363	206,200	1,216,071	2,892,634		2,892,634	(270,655)	2,621,979			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.
In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	6,143	30		9
10	Interest and Other Investment Income	(26,644)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(330)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(170)	21		18
19	Entertainment				19
20	Contributions	(1,000)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(480)	21		24
25	Fund Raising, Advertising and Promotional	(175)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(7,810)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (30,466)		\$	30

OHF USE ONLY							
48		49		50		51	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(240,189)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (240,189)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (270,655)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS		Page 5A
OREGON HEALTHCARE CENTER		
ID# 0037838		
Report Period Beginning:	01/01/02	
Ending:	12/31/02	
		Sch. V Line
NON-ALLOWABLE EXPENSES		
	Amount	Reference
1 CABLE TV INCOME	\$ (1,022)	5 1
2 VETERANS EXP., PHARMACY	(2,837)	10 2
3 R.D. ACCOUNTING FEES	(429)	21 3
4 REPLACEMENT TAX, Oregon Associates	(3,831)	21 4
5 TRUST FEES	(500)	21 5
6		6
7		7
8		8
9		9
10		10
11		11
12		12
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93		93
94		94
95		95
96		96
97		97
98		98
99		99
100		100
101 Total	(7,810)	101

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

[illegible]

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ **X** **YES** ☐ **NO**

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rental Income	\$ 341,640	Oregon Associates	100.00%	\$	\$ (341,640)	1
2	V	32	Interest Income	88,154	Oregon Associates	100.00%		(88,154)	2
3	V	32	Interest Expense		Oregon Associates	100.00%	130,491	130,491	3
4	V	21	Accounting		Oregon Associates	100.00%	420	420	4
5	V	30	Depreciation Expense		Oregon Associates	100.00%	25,222	25,222	5
6	V	31	Amortization Expense		Oregon Associates	100.00%	3,436	3,436	6
7	V	21	Replacement Tax		Oregon Associates	100.00%	3,031	3,031	7
8	V	21	Gain/Loss on Partnership	354	Oregon Associates	100.00%		(354)	8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$ 430,149			\$ 162,600	\$ * (267,549)	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	\$	S.W. MANAGEMENT	100.00%	\$ 1,207	\$ 1,207	15
16	V	6	REPAIRS AND MAINT.		S.W. MANAGEMENT		1,148	1,148	16
17	V	17	CHIEF FINANCIAL OFFICER		S.W. MANAGEMENT		11,276	11,276	17
18	V	19	PROFESSIONAL FEES		S.W. MANAGEMENT		342	342	18
19	V	20	FEES, SUBSCRIPTIONS, DUES		S.W. MANAGEMENT		44	44	19
20	V	21	CLERICAL AND GENERAL		S.W. MANAGEMENT		33,772	33,772	20
21	V	24	EDUCATION AND SEMINARS		S.W. MANAGEMENT		5	5	21
22	V	25	TRANSPORTATION		S.W. MANAGEMENT		288	288	22
23	V	26	INSURANCE - PROPERTY		S.W. MANAGEMENT		793	793	23
24	V	27	PAYROLL TAXES		S.W. MANAGEMENT		6,632	6,632	24
25	V	30	DEPRECIATION		S.W. MANAGEMENT		1,319	1,319	25
26	V	32	INTEREST EXPENSE		S.W. MANAGEMENT		1,016	1,016	26
27	V	33	REAL ESTATE TAXES		S.W. MANAGEMENT		2,658	2,658	27
28	V	35	AUTO LEASE				785	785	28
29	V				S.W. MANAGEMENT				29
30	V	17	SALARY - SHELDON WOLFE		S.W. MANAGEMENT		53,586	53,586	30
31	V	17	SALARY - RONNIE KLEIN		S.W. MANAGEMENT		5,000	5,000	31
32	V	27	EMP. BEN.-SHELDON WOLFE		S.W. MANAGEMENT		2,112	2,112	32
33	V	27	EMP. BEN.-RONNIE KLEIN		S.W. MANAGEMENT		696	696	33
34	V								34
35	V	17	MANAGEMENT FEES	60,000	S.W. MANAGEMENT			(60,000)	35
36	V	19	HOME OFFICE FEES	70,800	S.W. MANAGEMENT			(70,800)	36
37	V								37
38	V								38
39	Total			\$ 130,800			\$ 122,679	\$ * (8,121)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES

☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	PROFESSIONAL FEES	\$	SFO ASSOCIATES	100.00%	\$ 7,025	\$ 7,025	15
16	V	32	INTEREST		SFO ASSOCIATES		159,245	159,245	16
17	V								17
18	V								18
19	V								19
20	V	32	INTEREST	130,166	SFO ASSOCIATES			(130,166)	20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 130,166			\$ 166,270	\$ * 36,104	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES

☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	DIETARY SUPPLEMENTS	\$ 4,194	S & E MEDICAL SUPPLY	100.00%	\$ 3,775	\$ (419)	15
16	V	10	MEDICAL SUPPLIES	1,018	S & E MEDICAL SUPPLY	100.00%	814	(204)	16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 5,212			\$ 4,589	\$ * (623)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐

YES

☐

NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐

YES

☐

NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐

YES

☐

NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	SHELDON WOLFE	President	Administrative	31.74%	See Attached	5	8.34%	Alloc SW Mg	\$ 53,586	17-7	1
2	RONNIE KLEIN	Treasurer	Administrative	15.87%	See Attached	5	8.34%	Alloc SW Mg	5,000	17-7	2
3	RONNIE KLEIN	Treasurer	Administrative	15.87%	See Attached			Fees Facility	60,000	17-3	3
4	MO HERMAN	CFO	Financial	2.40%	See Attached	3.1	7.75%	Alloc SW Mg	11,276	17-7	4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 129,862		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number OREGON HEALTHCARE CENTER # 0037838 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☒

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number
Fax Number

()

()

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Ending: 12/31/02

(847) 982-2304

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number OREGON HEALTHCARE CENTER # 0037838 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization SFO ASSOCIATES
Street Address 7434 N. SKOKIE BLVD.
City / State / Zip Code SKOKIE, IL. 60077
Phone Number (847) 982-2300
Fax Number (847) 982-2304

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	19	PROFESSIONAL FEES	NOTE RECEIVABLE	6,500,000	3	\$ 22,832	\$	2,000,000	\$ 7,025	1
2	32	INTEREST	NOTE RECEIVABLE	6,500,000	3	517,545		2,000,000	159,245	2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 540,377	\$		\$ 166,270	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number OREGON HEALTHCARE CENTER # 0037838 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization S & E MEDICAL SUPPLY
Street Address 3100 COMMERCIAL AVENUE
City / State / Zip Code NORTHBROOK, ILLINOIS 60062
Phone Number (847) 982-9300
Fax Number ()

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	DIETARY SUPPLEMENTS	DIRECT ALLOCATION						3,775	1
2	10	MEDICAL SUPPLIES	DIRECT ALLOCATION						814	2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$ 4,589	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number OREGON HEALTHCARE CENTER # 0037838 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number
Fax Number

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()

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number OREGON HEALTHCARE CENTER # 0037838 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number
Fax Number

()

()

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number OREGON HEALTHCARE CENTER # 0037838 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number
Fax Number

()

()

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number OREGON HEALTHCARE CENTER # 0037838 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number
Fax Number

()

()

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number OREGON HEALTHCARE CENTER # 0037838 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number
Fax Number

()

()

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number OREGON HEALTHCARE CENTER # 0037838 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number
Fax Number

()

()

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	Oregon Associates	X					\$	843,737			\$ 38,145	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						\$	843,737			\$ 38,145	9
	B. Non-Facility Related*											
10	See Supplemental Schedule							1,446,154			45,788	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						\$	1,446,154			\$ 45,788	14
15	TOTALS (line 9+line14)						\$	2,289,891			\$ 83,933	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ N/A Line #

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
1	Oregon Healthcare Center	X		Interest Income			\$				\$ (26,644)	1
2	Oregon Associates	X		Interest Income							(88,154)	2
3	Oregon Associates	X		Interest Expense				1,446,154			130,491	3
4	Allocated SFO	X		Interest Income							(130,166)	4
5	Allocated SFO	X		Interest Expense							159,245	5
6	Allocated SW Mgmt	X		Interest Expense							1,016	6
7												7
8												8
9												9
10												10
11												11
12												12
13												13
14												14
15												15
16												16
17												17
18												18
19												19
20												20
21							\$	1,446,154			\$ 45,788	21

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME

OREGON HEALTHCARE CENTER

COUNTY

OGLE

FACILITY IDPH LICENSE NUMBER

0037838

CONTACT PERSON REGARDING THIS REPORT

STEVE LAVENDA

TELEPHONE

(847) 236-1111

FAX #:

(847) 236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2001.

	(A)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
1.	18-16-04-476-009	Nursing Home	\$ 29,404.00	\$ 29,404.00
2.	See Attached	Allocation from SW Mgmt	\$ 35,720.85	\$ 2,665.07
3.			\$	\$
4.			\$	\$
5.			\$	\$
6.			\$	\$
7.			\$	\$
8.			\$	\$
9.			\$	\$
10.			\$	\$
		TOTALS	\$ 65,124.85	\$ 32,069.07

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? X YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill which is normally paid during 2002.

IMPORTANT NOTICE

TO:

Long Term Care Facilities with Real Estate Tax Rates

RE:

2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME

OREGON HEALTHCARE CENTER

COUNTY

OGLE

FACILITY IDPH LICENSE NUMBER

0037838

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ()

FAX #: ()

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

(A)	(B)	(C)	(D)
			<u>Tax</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Applicable to</u>
			<u>Nursing Home</u>
1.		\$	\$
2.		\$	\$
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$	\$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home.
(Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 19,900

B. General Construction Type: Exterior BRICK

Frame STEEL STUD

Number of Stories 1

C. Does the Operating Entity?

☐ (a) Own the Facility

☒ (b) Rent from a Related Organization.

☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?

☒ (a) Own the Equipment

☒ (b) Rent equipment from a Related Organization.

☐ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

NONE

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☒ YES

☐ NO

If so, please complete the following:

1. Total Amount Incurred: 113,078

2. Number of Years Over Which it is Being Amortized: 30

3. Current Period Amortization: 3,436

4. Dates Incurred: 1992

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	FACILITY		1992	\$ 50,000	1
2					2
3	TOTALS			\$ 50,000	3

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1		2	3	4	5	6	7	8	9	
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4					\$	\$		\$	\$		4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various		1992		6,160		20	94	94	6,126	9
10	Various		1993		26,517		20	1,325	1,325	12,866	10
11	Various		1994		5,324		20	266	266	2,513	11
12	Various		1995		3,498		20	175	175	1,327	12
13	Various		1996		2,042		20	102	102	645	13
14	Various		1997		2,880		20	144	144	804	14
15	Various		1998		65,055		20	3,253	3,253	16,792	15
16								-		-	16
17								-		-	17
18								-		-	18
19								-		-	19
20								-		-	20
21								-		-	21
22								-		-	22
23								-		-	23
24								-		-	24
25								-		-	25
26								-		-	26
27								-		-	27
28								-		-	28
29								-		-	29
30								-		-	30
31								-		-	31
32								-		-	32
33								-		-	33
34								-		-	34
35								-		-	35
36								-		-	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			\$	\$		\$ -	\$	\$ -	37
38						-		-	38
39						-		-	39
40						-		-	40
41						-		-	41
42						-		-	42
43						-		-	43
44						-		-	44
45						-		-	45
46						-		-	46
47						-		-	47
48						-		-	48
49						-		-	49
50						-		-	50
51						-		-	51
52						-		-	52
53						-		-	53
54						-		-	54
55						-		-	55
56						-		-	56
57						-		-	57
58						-		-	58
59						-		-	59
60						-		-	60
61						-		-	61
62						-		-	62
63						-		-	63
64						-		-	64
65						-		-	65
66						-		-	66
67						-		-	67
68	Related Party Allocations (Page 12-REP & Page 12A-REP)		1,049,924	26,314		26,608	294	283,133	68
69	Financial Statement Depreciation			3,775			(3,775)		69
70	TOTAL (lines 4 thru 69)		\$ 1,161,400	\$ 30,089		\$ 31,967	\$ 1,878	\$ 324,206	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 1,161,400	\$ 30,089		\$ 31,967	\$ 1,878	\$ 324,206	1
2	SEWER PIPES	1999	4,075		20	204	204	816	2
3	FLOOR TILES,WALLPAPE	1999	11,750		20	588	588	2,107	3
4	FLOOR TILES,WALLPAPE	1999	5,302		20	265	265	950	4
5	100 AMP FEEDER	1999	7,800		20	390	390	1,203	5
6	AIR CONDITIONERS	1999	734		20	37	37	133	6
7	AIR CONDITIONERS	1999	1,369		20	68	68	238	7
8	CORDSET	1999	1,053		20	53	53	194	8
9	ALARM	1999	1,188		20	59	59	396	9
10	FIRE DOOR	1999	912		20	46	46	236	10
11	FLOOR TILE	1999	506		20	25	25	131	11
12	AIR CONDITIONER	1999	1,369		20	68	68	433	12
13	MODEL 10KPA CODE A/R	2001	1,189		20	59	59	84	13
14	GENERATOR REPAIR	2001	1,010		20	51	51	60	14
15	MOTOR	2001	783		20	39	39	65	15
16	GLASS THERMO UNIT	2001	868		20	43	43	65	16
17	INSTALL BOARD	2001	816		20	41	41	55	17
18	GAS CONTROLLER	2001	739		20	37	37	46	18
19	CLUTCH & OUTPUT BRD	2001	1,138		20	57	57	71	19
20	VINYL FLOORING	2001	912		20	46	46	88	20
21	WALL-REPLACED	2002	5,000		20	146	146	146	21
22	AIR CONDITIONERS	2002	1,470		20	147	147	147	22
23	AIR CONDITIONERS	2002	1,366		20	80	80	80	23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 1,212,749	\$ 30,089		\$ 34,516	\$ 4,427	\$ 331,950	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$1,212,749	\$30,089		\$34,516	\$4,427	\$331,950	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$1,212,749	\$30,089		\$34,516	\$4,427	\$331,950	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$1,212,749	\$30,089		\$34,516	\$4,427	\$331,950	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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16									16
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19									19
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23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$1,212,749	\$30,089		\$34,516	\$4,427	\$331,950	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$1,212,749	\$30,089		\$34,516	\$4,427	\$331,950	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$1,212,749	\$30,089		\$34,516	\$4,427	\$331,950	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		\$1,212,749	\$30,089		\$34,516	\$4,427	\$331,950	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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20									20
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$1,212,749	\$30,089		\$34,516	\$4,427	\$331,950	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		\$1,212,749	\$30,089		\$34,516	\$4,427	\$331,950	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$1,212,749	\$30,089		\$34,516	\$4,427	\$331,950	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		\$1,212,749	\$30,089		\$34,516	\$4,427	\$331,950	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
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19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$1,212,749	\$30,089		\$34,516	\$4,427	\$331,950	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		\$1,212,749	\$30,089		\$34,516	\$4,427	\$331,950	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$1,212,749	\$30,089		\$34,516	\$4,427	\$331,950	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12I, Carried Forward		\$1,212,749	\$30,089		\$34,516	\$4,427	\$331,950	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$1,212,749	\$30,089		\$34,516	\$4,427	\$331,950	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12I, Carried Forward		\$ 1,212,749	\$ 30,089		\$ 34,516	\$ 4,427	\$ 331,950	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 1,212,749	\$ 30,089		\$ 34,516	\$ 4,427	\$ 331,950	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	FOR OHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	104		1992		\$1,008,880	\$25,222	35	\$25,222	\$	\$273,238	4
5	SW Mgmt		1995		33,576	861	35	959	98	7,343	5
6											6
7											7
8											8
	Improvement Type**										
9	ALLOCATED SW MGMT		1995		3,590	120	20	214	94	1,592	9
10	ALLOCATED SW MGMT		1996		627	16	20	31	15	206	10
11	ALLOCATED SW MGMT		1997		903	35	20	65	30	340	11
12	ALLOCATED SW MGMT		1998		622	16	20	31	(15)	148	12
13	ALLOCATED SW MGMT		1999		1,726	44	20	86	42	266	13
14	ALLOCATED SW MGMT										14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A-REP, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
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51									51
52									52
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55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$1,049,924	\$26,314		\$26,608	\$264	\$283,133	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$132,881	\$100	\$12,044	\$11,944	10	\$99,954	71
72	Current Year Purchases	3,889	10,412	184	(10,228)	10	184	72
73	Fully Depreciated Assets	232,395				10	232,395	73
74								74
75	TOTALS	\$369,165	\$10,512	\$12,228	\$1,716		\$332,533	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$1,631,914	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$40,601	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$46,744	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$6,143	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$664,483	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☒ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

**

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO

16. Rental Amount for movable equipment: \$ Description: (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Allocation SW MGMT		\$	\$ 785	17
18					18
19					19
20					20
21	TOTAL		\$	\$ 785	21

10. Effective dates of current rental agreement:

Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2003	\$
13.	/2004	\$
14.	/2005	\$

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?

☒ YES

☐ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER AIDE

☒

☒

☐

80

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER AIDE

☒

☒

12

B. EXPENSES

		ALLOCATION OF COSTS (d)			
		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$ 800	\$	\$ 800
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$ 800	\$	\$ 800
10	SUM OF line 9, col. 1 and 2 (e)	\$ 800			

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	<u>2</u>
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	2

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.
- SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 03	hrs	\$		\$ 44,812	\$		\$ 44,812	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			9,003			9,003	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			78,809			78,809	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescripts				20,856		20,856	9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							
10			hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): See Supplemental						3,139		3,139	13
14	TOTAL			\$		\$ 132,624	\$ 23,995		\$ 156,619	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

This report must be completed even if financial statements are attached.

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 562,920	\$ 564,665	1
2	Cash-Patient Deposits	10,457	10,457	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	368,171	368,171	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	13,623	13,623	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	333,824	1,888,995	8
9	Other(specify): See Supplemental Schedule		33,080	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,288,995	\$ 2,878,991	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		50,000	13
14	Buildings, at Historical Cost		1,008,880	14
15	Leasehold Improvements, at Historical Cost	87,699	87,699	15
16	Equipment, at Historical Cost	206,982	412,982	16
17	Accumulated Depreciation (book methods)	(207,568)	(686,806)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		113,078	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(38,979)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Supplemental Schedule			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 87,113	\$ 946,854	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,376,108	\$ 3,825,845	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 69,738	\$ 69,737	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	13,477	13,477	28
29	Short-Term Notes Payable	843,737	843,737	29
30	Accrued Salaries Payable	36,476	36,476	30
31	Accrued Taxes Payable (excluding real estate taxes)	4,107	4,107	31
32	Accrued Real Estate Taxes(Sch.IX-B)	30,875	30,875	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Supplemental Schedule			36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 998,410	\$ 998,409	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		1,446,154	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Supplemental Schedule			43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 1,446,154	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 998,410	\$ 2,444,563	46
47	TOTAL EQUITY(page 18, line 24)	\$ 377,698	\$ 1,381,282	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,376,108	\$ 3,825,845	48

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 219,356	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 219,356	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	158,342	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 158,342	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 377,698	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

1			
	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 2,903,968	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,903,968	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	105,681	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 105,681	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	66	14
15	Telephone, Television and Radio	1,218	15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	12,748	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 14,032	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	26,644	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 26,644	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Supplemental Schedule</u>	651	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 651	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,050,976	30

2			
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	679,741	31
32	Health Care	947,297	32
33	General Administration	627,867	33
	B. Capital Expense		
34	Ownership	424,170	34
	C. Ancillary Expense		
35	Special Cost Centers	156,619	35
36	Provider Participation Fee	56,940	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,892,634	40
41	Income before Income Taxes (line 30 minus line 40)**	158,342	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 158,342	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? Cash Basis If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number OREGON HEALTHCARE CENTER

0037838

Report Period Beginning:

01/01/02

Ending:

12/31/02

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,080	2,080	\$ 46,212	\$ 22.22	1
2	Assistant Director of Nursing					2
3	Registered Nurses	5,747	5,919	111,065	18.76	3
4	Licensed Practical Nurses	10,423	11,107	184,231	16.59	4
5	Nurse Aides & Orderlies	50,780	52,235	527,002	10.09	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	4,475	4,884	51,339	10.51	10
11	Social Service Workers	1,592	1,632	20,339	12.46	11
12	Dietician					12
13	Food Service Supervisor	1,818	1,906	20,914	10.97	13
14	Head Cook					14
15	Cook Helpers/Assistants	17,849	18,935	142,704	7.54	15
16	Dishwashers					16
17	Maintenance Workers	2,298	2,486	39,334	15.82	17
18	Housekeepers	16,423	17,625	149,363	8.47	18
19	Laundry	8,032	8,517	55,214	6.48	19
20	Administrator	2,080	2,080	51,140	24.59	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,768	3,948	71,506	18.11	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>					33
34	TOTAL (lines 1 - 33)	127,365	133,354	\$ 1,470,363 *	\$ 11.03	34

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	98	\$ 6,355	01-03	35
36	Medical Director	98	3,900	09-03	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	180	9,000	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant	1	42	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	377	\$ 19,297		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		\$		53

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount		Description	Amount
DEBRA ADKINS	Administrator	0%	\$ 51,140	Workers' Compensation Insurance	\$	36,289	IDPH License Fee	\$
				Unemployment Compensation Insurance		11,935	Advertising: Employee Recruitment	1,000
				FICA Taxes		112,411	Health Care Worker Background Check	348
				Employee Health Insurance		65,643	(Indicate # of checks performed 29)	
				Employee Meals			Dues & Subscriptions	659
				Illinois Municipal Retirement Fund (IMRF)*			Inspections/Permits	875
				Misc. Employee Benefits/Disability		1,070	Licenses	435
				Holiday Expense		330		
TOTAL (agree to Schedule V, line 17, col. 1)							Alloc. SW Mgmt	44
(List each licensed administrator separately.)								
B. Administrative - Other							Less: Public Relations Expense	()
Description			Amount				Non-allowable advertising	()
RONNIE KLEIN			\$ 60,000				Yellow page advertising	()
SW MGMT			60,000					
TOTAL (agree to Schedule V, line 17, col. 3)				TOTAL (agree to Schedule V,	\$	227,678		
(Attach a copy of any management service agreement)				line 22, col.8)				
C. Professional Services				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Vendor/Payee	Type		Amount	Description	Line #	Amount	Description	Amount
Winston & Strawn	Legal		\$ 520				Out-of-State Travel	\$
SW Mgmt	Home Office		70,800					
FR&R	Accounting		13,271					
							In-State Travel	
							Seminar Expense	1,029
							Allocation SW Mgmt	5
							Entertainment Expense	()
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL			(agree to Sch. V,	
(If total legal fees exceed \$2500 attach copy of invoices.)					\$		line 24, col. 8)	
			\$ 84,591				TOTAL	\$ 1,034

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).

(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1	N/A		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number		OREGON HEALTHCARE CENTER		STATE OF ILLINOIS				Page 23
		#	0037838	Report Period Beginning:	01/01/02	Ending:	12/31/02	

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union?

NO

(2) Are there any dues to nursing home associations included on the cost report?

NO

If YES, give association name and amount.

(3) Did the nursing home make political contributions or payments to a political action organization?

YES

If YES, have these costs been properly adjusted out of the cost report?

YES

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year?

NO

If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases?

YES

What was the average life used for new equipment added during this period?

10 YRS

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.

\$

Line

N/A

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports?

YES

If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement?

NO

If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement?

YES

X

NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)?

YES

NO

X

If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period.

\$

56,940

This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee?

NO

If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V?

YES

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B?

NO

For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V.

\$

N/A

Has any meal income been offset against related costs?

Indicate the amount.

\$

(16) Travel and Transportation

a. Are there costs included for out-of-state travel?

NO

If YES, attach a complete explanation.

b. Do you have a separate contract with the Department to provide medical transportation for residents?

NO

If YES, please indicate the amount of income earned from such a program during this reporting period.

\$

N/A

c. What percent of all travel expense relates to transportation of nurses and patients?

None

d. Have vehicle usage logs been maintained?

N/A

e. Are all vehicles stored at the nursing home during the night and all other times when not in use?

N/A

f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?

YES

g. Does the facility transport residents to and from day training?

NO

Indicate the amount of income earned from providing such transportation during this reporting period.

\$

(17) Has an audit been performed by an independent certified public accounting firm?

NO

Firm Name:

The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached?

If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V?

YES

(19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report?

N/A

Attach invoices and a summary of services for all architect and appraisal fees

SEE ACCOUNTANTS' COMPILATION REPORT